

REFERRAL FOR CIVILIAN MEDICAL CARE

SUBMIT CHARGES TO: ☐ REFERRING UNIFORMED SERVICES FACILITY ☐ CHAMPUS

MEDICAL RECORD	CONSULTATION SHEET
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REQUEST		
TO:	FROM: <i>(Requesting physician or activity)</i>	DATE OF REQUEST

REASON FOR REQUEST *(Complaints and findings)*

ANTICIPATED LENGTH OF TREATMENT:

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED*	PLACE OF CONSULTATION	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> TODAY
		<input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input type="checkbox"/> 72 HOURS	<input type="checkbox"/> EMERGENCY

CONSULTATION REPORT

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; hospital or medical facility)*

DD Form 2161, OCT 78 (EG)

Designed using Perform Pro, WHS/DIOR, Apr 96

PATIENT/RESPONSIBLE FAMILY MEMBER SIGNATURE _____
SPONSOR'S FULL SSAN _____

IMPORTANT INFORMATION *(on reverse side)*

APPROVAL

*Signature of Commander or designated representative must appear in "approved" block on front of form.

PATIENT INFORMATION

As you have been advised, your physician has determined that you require the medical services shown on the front of this form. These specific services are not available at this medical facility. After considering other sources of care available for you, your physician has recommended that you get the medical services you need from local civilian sources. The Uniformed Services regulation covering payment for civilian medical care requires that claims for the civilian care recommended by your physician be sent to:

- a. ☐ **THIS MEDICAL FACILITY.** Charges to you will be the same as if you received the care in this facility.
- b. ☐ **CHAMPUS.** Charges to you will be as prescribed under current terms of the CHAMPUS program.

The Health Benefits Coordinator at this facility will answer any questions you have concerning this determination. If the charges are being submitted for **CHAMPUS** consideration, insure that the Health Benefit Coordinator fully explains program cost-sharing provisions, allowable charges, provider participation, and claim filing procedures for your particular case. You should also:

- a. Make arrangements to see the type of civilian provider recommended by your physician at this facility.
- b. File your **CHAMPUS** claims regularly (every 30 days.). Attach a copy of this form with each **CHAMPUS** claim submitted for care recommended.
- c. Your signature on the front of this form indicates your understanding of how payment will be made for the medical services recommended on the front of the form.

INFORMATION FOR CIVILIAN PROVIDERS OF CARE

This patient is being referred to you for the services indicated on the front of this consultation sheet. Your charges should be submitted to:

☐ _____ Please send your itemized
NAME OF THE UNIFORMED SERVICES MEDICAL FACILITY

bill with this completed consultation sheet to:

Complete mailing address
of referring medical facility

NOTE: Use provided pre-addressed envelope for return of consultation report.

☐ **CHAMPUS.** (1) Conditions for participation in the **CHAMPUS** program, are described on the **CHAMPUS** claim form. We encourage provider participation. Participating providers should send properly completed claims to:

Address of **CHAMPUS**
Contractor for your area

**Send completed consultation
report to:**

NOTE: Use provided pre-addressed envelope for return of consultation report.

- (2) If you elect not to participate in the **CHAMPUS** program, please give the patient an itemized statement of your services, including diagnostic information (ICDA or DSM II is acceptable). The patient is responsible to you for payment arrangements. **CHAMPUS** payment will be made to patient.

Health Benefits Advisor signature _____

PLEASE INCLUDE A COPY OF THIS COMPLETED CONSULTATION SHEET WITH EACH CHAMPUS CLAIM YOU SUBMIT TO THE CONTRACTOR.